A COMPARATIVE STUDY OF CLINICAL FEATURES, QUALITY OF LIFE IN OBSESSIVE COMPULSIVE DISORDER

Dissertation submitted in

THE TAMILNADU
Dr.M.G.R.MEDICAL UNIVERSITY

in partial fulfillment of the regulation
for the award of

M.D. (PSYCHIATRY)
BRANCH - XVIII

GOVT. STANLEY MEDICAL COLLEGE & HOSPITAL
THE TAMILNADU DR.M.G.R.MEDICAL UNIVERSITY
CHENNAI, INDIA

MARCH 2010

CERTIFICATE

This is to certify that this dissertation entitled **"A COMPARATIVE STUDY OF CLINICAL FEATURES, QUALITY OF LIFE IN OBSESSIVE COMPULSIVE DISORDER"** is a bonafide work done by **Dr.R.JAISINGH,** in partial fulfillment of the requirements of GOVT. STANLY MEDICAL COLLEGE & HOSPITAL, THE TAMIL NADU DR.M.G.R. MEDICAL UNIVERSITY, Chennai for the award of **M.D. Psychiatry Degree.**

GUIDE

Prof. Dr.M.THIRUNAVUKARASU,
M.D., (Psych)., DPM, FIPS.,
Professor & Head of Department,
Department of Psychiatry
Stanley Medical College & Hospital
Chennai – 600001.

Prof.Dr.A.PRIYA, M.S., D.O.,
DEAN
Govt. Stanley Medical College & Hospital,
Chennai – 600 001.

ACKNOWLEDGEMENT

I wish to thank **Prof.Dr.A.PRIYA, M.S., D.O.,** Dean, Stanley Medical College for permitting me to carry out this study.

With sincere gratitude, I wish to acknowledge the expert guidance and precise suggestions of **Prof.Dr.M.THIRUNAVUKARASU, M.D., (Psych), DPM., FIPS,** Professor and Head, Department of Psychiatry who has helped in designing the study. I thank him for being a constant source of encouragement, inspiration, not only in this study but in all my professional endeavours.

I sincerely express my grateful thanks to **Dr.G.S.CHANDRALEKA, M.D., DPM.,** Additional Professor, Department of Psychiatry, for being a constant source of encouragement and inspiration in this study.

I express my profound gratitude to **Dr.M.SURESH KUMAR, M.D., DPM., MPH.,** consultant psychiatrist, Chennai.

My sincere thanks to **Dr.S.NAKKERAR, DPM.,** Assistant Professor, Institute of Mental Health, Chennai and **Dr.M.MOHAMED ILYAS, M.D., DPM.,** Assistant Professor, Department of Psychiatry for their constructive criticisms, without which this work would not be in the present shape.

I sincerely thank **Dr.V.VENKATESH MATHAN KUMAR, M.D.,** Assistant Professor, Department of Psychiatry.

I wish to thank all my Co-postgraduates and other staff members of the Department without their help this thesis would not have been completed.

I extend my thanks to all patients who participated in this study. Above all, my whole hearted thanks to my parents, family members and friends for their moral support and encouragement.

INDEX

REFERENCES

1. Mendlowicz MV, stein MB, quality of life in individuals with anxiety disorders. Am J Phychiarty 2ooo.

2. Skevington SM Lotfy M, O'Connell KA. The World Health Organization's WHOQOL – BREF quality of life assessment: Psychometric properties and results of the international field. A report from the WHOQOL group. Quality of life 2oo4.

3. Koran LM, Theineman ML, Davenport R. Quality of life for patients with obsessive-compulsive disorder 1996.

4. Stengler-Wenzke K, Kroll M, Matschinger H, Angermeyer MC. Subjective quality of life of patients with obsessive – compulsive disorder. Society Physchiatry Physchiatr Epidemiol 2006.

5. Lochner C, Mogotsi M, du Toit PL, Kaminer D, Niehaus DJ, Stein DJ. Quality of life in anxiety disorders: a comparison of obsessive –compulsive disorder, social anxiety disorder, and panic disorder. Psycholpathol 2003.

6. Bobes J, Gonzalez MP, Bascaran MT, Arango C, Saiz PA, Bousono M. Quality of life and disability in patients with obsessive – compulsive disorder. Eur Psychiatry 2oo1.

7. Moritz S, Rufer M, Fricke S, etal. Qualify of life in obsessive – compulsive disorder before and after treatment. Compr Psychiatry 2oo5.

8. Sorensn CB, Kirkeby L. Thomsen PH.W. Quality of life with OCD. A self – reported survey among members of the Danish OCD Association. Nord J Psychiatry 2oo4.

9. Eisen JL, Mancebo MA, Pinto A, etal. Impact of obsessive – compulsive disorder on quality of life. Compr Psychiatry 2oo6.

10. Rodriguez – Salgado B, Dolengevich – Segal H, Arrojo-Romero M, etal. Perceived quality of life in obsessive – compulsive disorder: related factors. BMC Psychiatry 2oo6.

11. Hollander E, Kwon JH, Stein DJ, Broatch J. Rowland CT, Himelein CA. obsessive – compulsive disorder. : overview and quality of life issues. J Clin Psychiatry 1996.

12. stein DJ. Roberts M, Hollander E, Rowland C, Serebro P. Quality of life and pharmaco-economic aspects of obsessive – compulsive disorder. A South African survey. S Afr Med J 1996.

13. Leon Ac, Portera L, Weissman MM. The social costs of anxiety disorders. Br J Phychiatry 1995.

14. Mancebo MC, Greenberg B, Grant JE, et age limit. Correlates occupational disability in a clinical sample of obsessive – compulsive disorder. Compr Psychiatry 2oo8.

15. Dupont RL, Rice DP, Shiraki S, Rowland CR. Economic costs of obsessive – compulsive disorder Med Interface1995.

16 Quilty LC, Van Amerigen M, Mancini C, Oakman J, Farvolden P. Quality of life and the anxiety disorders. J Anxiety Disord 2oo3.

17. Bystritsky A, Liberman RP, Hwang S, et age limit, Social functioning and quality of life comparisons between obsessive – compulsive disorders. Depress anxiety 2oo1.

18. Masellis M, Rector nA. Quality of life in OCD: differential impact of obsessions, compulsions, and depression comorbidity. Can J Psychiatry 2oo3.

19. Moritz S. Meier B, Kloss M, etal, Dimensional structure of the yale-brown obsessive – compulsive scale (Y-BOCS). Phychiatry 2oo2.

20. Diefenbach GJ, Abramowitz JS, Norberg MM, Tolin DF. Changes in Quality of life following cognitive-behavioural therapy for obsessive – compulsive disorder. Behav Respondent Ther 2oo7.

21. Besiroglu L, AS, Cl, Askin R. The predictors of health care seeking behaviour in obsessive – compulsive disorder. Compr Psychiatry 2oo4.

22. Demal U. Lenz G, Mayrhofer A, Zapotoczky HG, zitterl W. obsessive – compulsive disorder and depression. A retrospective study on course and interaction. Psychopathol 1993.

23. Apter A, Horesh N, Gothelf D, etal Depression and suicidal behaviour in adolsescent in-patients with obsessive – compulsive disorder. J Affect Disord 2oo3.

24. Perugi G, Akiskal HS, Pfanner C, etal. The clinical impact of bipolar and uniploar affective comorbidity on obsessive – compulsive disorder. J Affect Disord 1997.

25. Piacentini J, Bergman RL, Keller M, McCracken J. Functional impairment in children and adolescents with obsessive – compulsive disorder. J Child Adolesc Phychophamacol 2oo3.

26. Katschnig H : How useful is the concept of Quality of life in Psychiatry ? Quality of life in mental disorders. Edited by Katschnig H, Freeman H, Sartorius N. New York, John Wiley & Sons 1997.

27. Staquet MJ, Hays RD, Fayers PM (eds): Quality of life assessment in clinical trials: Methods and practice. New York, oxford university press 1998.

28. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 196o.

29. Broadhead WE, Blazer DG< George LK, Tse CK: depression, disability days and days lost from work in a prospective epidemiologic survey. JAMA 199o.

30. Antony MM, Roth D, Swinson RP Huta V, Devins GM:Illness intrusiveness in individuals with panic disorder, obsessive – compulsive disorder or social phobia. J Nerv Ment Dis 1998.

31. Rapaport MH, Clary C, Fayyad R, Endicott J. Quality of life impairment in depressive and anxiety.

32. Moussavi S, Chatterji S, Verdes E etal. Depression, chronic diseases, and decrements in health: results from the World Health Survey. Lancet 2007; 370:851-858

33. Das-Munshi J, Goldberg D, Bebbington PE, etal. Publich Heath significance of mixed anxiety and depression : beyond current classification. Br. J Psychiatry 2008.

34. Strine TW, Chapman DP, Balluz LS, etal. The associations between life satisfaction and health related Quality of life, chronic illness and health behaviours among U.S. community –dwelling adults. J. Community Health 2008.

35. World Heath Organisation (1992): The ICD 10 classification of mental and behavioral disorders: diagnostic criteria for research. Geneva : World Health Organisation.

36. Emmel kamp, P.M.G., deHaan, E., Hoogduin C.A.L (1990) Marital adjustment and obsessive – compulsive disorder. British journal of Psychiatry 156,55-60

37. Chakrabarthi, S. Kulhara, P and Verma, S.K. (1993) The pattern of burden in families of neurotic patients, social Psychiatry and Psychiatric epidemiology 28, 172-177

38. Cooper, M (1993) A group of families of obsessive – compulsive persons: The journal of contemporary human services, 74, 301-307

39. Elizsondo, D.M, calamari, J.E, Janeck, A.S (1996) Quality of life in obsessive – compulsive disorder.

40. KIM; SW; Dysken M.W. Kushkowski, M? (1990) The yale brown obsessive – compulsive scale; a reliability and validity study Psychiatric research, 34, 99-106.

41. Didie ER, Walters MM, Pinto A, etal. A comparison of Quality of life and psychosocial functioning in obsessive – compulsive disorder and body dysmorphic disorder. Ann Clin Psychiatry 2007; 19: 181-186

42. Whitaker A, Johnson J, Shaffer D, Rapoport JL, Kalikow K, Walsh BT, Davies M, braiman S, Dolinsky A: uncommon troubles in young people; prevalence estimates of selected Psychiatry disorders in a non referred adolescent population. Arch Gen Psychiatry 1990; 47;487-496

43. Skoog G, Skoog I: A 40 year follow up of patients with obsessive – compulsive disorder. Arch Gen Psychiatry 1999; 56: 121-127

44. Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR, Charney DS: The yale – brown obsessive – compulsive scale, I: development, use, and reliability. Arch Gen Psychiatry 1989; 46; 1006-1011

45. Miguel EC, Coffey BJ, Baer L, Savage CR, Rauch SL, Jenike MA: Phenomenology of international repetitive behaviours in obsessive – compulsive disorder and Tourette's syndrome. J Clin Psychiatry 1995;56; 246-255

46. Gelter DA, Biederman J, Jones J, Shapiro S, Schwartz S, Park KS: obsessive – compulsive disorder in children and adolescents : a review. Harv Rev Psychiatry 1998; 5:260-273

47. Swedo SE, Leonard HL, Garvey M, Mittleman B, Allen AJ, Perimutter S, Dow S, Zan. Koff J, Dubbert BK, Lougee L: Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections: clinical description of the first 50 cases. Am J Psychiatry 1998; 155:264-271; correction , 155:578

48. Hollander E, Kwon JH, Stein DJ, Broatch J, Rowland CT< Himelein CA. obsessive – compulsive and spectrum disorders: Overview and Quality of life issues. J Clin Psychiatry. 1996; 57 (suppl 8) 3-6

49. Elsen JL, Mancebo MA, Pinto A, Coles ME, Pagano ME, Stout R, Rasmussen SA, Impact of obsessive – compulsive disorder on Quality of life, Compr Psychiatry

50. Rodriguez – Salgado B, Dolengevich – Segal H, Arrojo – Romero M, Castelli – Candia P, Navio- Acosta M, Perez – Rodriguez MM, Saiz Ruiz J, Baca Garcia E, Perceived Quality of life in obsessive – compulsive disorder : related factors. BMC Psychiatry

51. Calvocoressi L, Libman D, Vegso SJ, McDougle CJ, Price LH. Global functioning of in-patients with obsessive – compulsive disorder, schizophrenia, and major depression. Psychiatr Serv. 1998; 49(3): 379-81

52. Rapaport MH, Clary C, Fayyad R, Endicott J. Quality of life impairment in depressive and anxiety disorders. Am J Psychiatry 05; 162(6): l 171-8

53. Moritz S, Rufer M, Fricke S, Karow A, Morfeld M, Jelinek L, Jacobsen D. Quality of life in obsessive – compulsive disorder before and after treatment. Compr Psychiatry 2005;46:453-9

54. Koran LM. Quality of life in obsessive – compulsive disorder. Psychiatr Clin North Am. 2000; 23(3):50-17

55. Vikas A, Avasthi and Sharan P Psychological impact of obsessive compulsive disorder on patients and their care givers: a comparative study with. depressive disorder. Int J Soc Psychiatry, 2009.

56. Cassin SE, Richter MA, Zhang KA, Rector NA. Quality of Life in Treatment-Seeking Patients With Obsessive–Compulsive Disorder With and Without Major Depressive Disorder. Can J Psychiatry. 2009;54(7):460–467.

57. Foa EB, Kozak MJ, Salkovskis PM, Coles ME, Amir N. The validation of a new obsessive-compulsive disorder scale: the Obsessive–Compulsive Inventory. Psychol Assess 1998; 10: 206–14.

58. Fontenelle LF, Mendlowicz MV, Marques C, Versiani M. Trans-cultural aspects of obsessive–compulsive disorder: a description of a Brazilian sample and a systematic review of international clinical studies. J Psychiatr Res 2004;38:403–11.

59. Fontenelle LF, Hasler G. The analytical epidemiology of obsessive–compulsive disorder: Risk factors and correlates. Progress in Neuro-Psychopharmacology & Biological Psychiatry 32 (2008) 1–15.

60. Lewis A. Problems of obsessional illness. Proc R Soc Med 1986;29:325–36.

INFORMED CONSENT

I am resident, doing MD Psychiatry in Stanley Medical College, Chennai. As part of my training, I am conducting a research among 30 persons with obsessive compulsive disorder and 30 persons with Major depression on the topic 'A study of Clinical Features.Quality of Life in obsessive compulsive disorder': A Case Control Study. I have prepared an interview schedule for this research, which would be administered personally to all the respondents. In addition, only for the 30 persons with obsessive – compulsive disorder, I'll also be administering a standardized questionnaire related to their clinical symptoms.

The purpose of study :A study of Clinical Features, Quality of Life in obsessive compulsive disorder: A Case Control Study.

Age group of the respondents: 18-60 years

Method of data collection : Personal Interviews

Tool of data collections : Interview schedule and standardized questionnaires

Time required to complete : 60 to 90 minutes

Benefits of the study : There will not be any direct benefit out of this research. The researcher will help in increasing the awareness about the conditions under study namely, obsessive compulsive disorder and major depression. All respondents are registered in Department of Psychiatry, Stanley Medical College and will receive free

	medicines, phycho therapy and psycho education.
Use of Information collected	: The information collected would be used only for academic purposes and data confidentiality would be maintained by the researcher and the institution concerned.
Risks	: Sensitive questions may be avoided if the respondent does not feel comfortable answering them. The questions are framed only to ascertain the clinical characteristics and possible associated factors.
Contact Person	: The researcher can be contacted over the phone for any clarifications and explanations regarding this study, in the numbers +91 9443593207 or 044xxxxxxxx, Extension No. yyy, Department of Psychiatry, Stanley Medical College hospital.

If you consent to be a respondent in this research, you can clarify all your doubts from the researcher, even before the interview. Kindly sign below for proceeding further. Your participant is purely voluntary.

Signature of the Respondent : Date:

Witness : Date:

INTRODUCTION

Obsessive Compulsive disorder (OCD) is a common, chronic disabling and often debilitating disorder, marked by obsessions and compulsions. Obsessions are described as recurrent intrusive, distressing thoughts, images, or impulses, which the patients recognizes as irrational. Compulsions are repetitive behaviours or mental acts that the patient feels driven to perform to prevent or to reduce distress or feared situation.

The recognition of obsessive compulsive disorder (OCD) as a distinct mental disorder began in the 19th century. In 1877, the German Psychiatrist West Phal used the term '*Zwang vorstellung*' (Compelled presentation or idea) to describe OCD pathology. Nineteenth century French descriptions related this disorder to doubt or what was called "Insanity with insight". Esquirol (1837) and Legren du Salle (1875) related this syndrome to doubt (Folie du doute) and disease of the will (Deliredu toucher). Janet called this as psychasthenia and stressed the relationship with low mental energy. The British translated Westphal's term as "Obsession" and the Americans as "Compulsions".

Obsessive compulsive disorder which was once thought to be uncommon condition has been increasingly recognized now. The life time prevalence of this disorder is between 2 to 3% in general population. It is

twice as prevalent as schizophrenia and bipolar disorder and the fourth most common psychiatric disorder. Above all, 50 – 60% of the OCD patients also experience two or more co-morbid psychiatric conditions during their life time. However, OCD has not received due attention of the clinicians, researchers and policy makers because it is a non psychotic illness.

OCD is being labeled a “hidden epidemic” and ranked 20th in global burden of disease among all diseases as a cause of disability – adjusted life years lost in developed countries. Available evidence indicates that OCD patients report general impairment in their functioning, and report poor quality of life (QOL). They also suffer from disability in several areas, particularly in marital, occupational, emotional and social functioning. More severe OCD symptoms were associated with general impairment in functioning. There is evidence that even the treatment responders continue to experience poor QOL. Depression and obsessions are the symptom clusters that most strongly contribute to low QOL. Because of the demoralization and hopelessness caused by obsessive compulsive symptoms, these patients view their life as worthless, but studies on clinical features and quality of life in obsessive compulsive disorder, compared to depression are very few which made us to take up this study.

In view of significance of quality of life as an indication of needs for care for the population that is being studied, I chose to study this aspect among the Obsessive Compulsive Disorder, a neglected field in Psychiatry. It was proposed to study the clinical features and assess the quality of life in them in comparison with another disabling condition, namely, major depression.

REVIEW OF LITERATURE

The quality of life (QOL) is increasingly recognized as a pivotal outcome parameter in research on obsessive – compulsite disorder (OCD). Studies using generic (ie – illness unspecific) instruments have confirmed poor QOL in OCD patients across a wide range of domains, especially with respect to social, work role functioning and mental health aspects.

A comprehensive definition is provided by the World Health Organization (WHO) which described QOL as the individuals perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations standards and concerns. A common denominator of health related QOL scales in the individuals perspective on multiple dimensions including functional (eg) work, physical, psychological and social aspects.

As early as 1975, persons with OCD are reported to have mild to moderate level of disturbance in several functions (Marks et al 1975). These findings were replicated by Foa and Goldstein in 1978.

According to a Canadian survey impairment and distress were experienced from obsessions by 26% and from compulsions by 22%. The

ECA study reported findings on employment and marital status showed significant functional impairment and high mental health care utilization.

Leon and others (1995) noted that 22% of men and 13% of women with OCD were receiving disability payments. Overall 20 – 30% of men and women with OCD received some type of financial assurance.

Koran and others (1996) found that 22% of treatment seeking OCD samples was unemployed. Handerson and pollard (1988) did not find significant difference in income levels between adults diagnosed with OCD and without this disorder.

According to ECA findings 21% of OCD – diagnosed respondents were single. Karno and others (1988) stated OCD more often occurs among divorced or separated respondents, although marital disruption was not specific to OCD. Early onset of illness in males may lead to remaining single thought the rest of their life.

Rapaport et al compared quality of life impairment in depressives and anxiety disorders. The proportion of patients with clinically severe impairment (two or more standard deviations below the community norm) in quality of life, varied with different diagnosis – major depressive disorder (63%) chronic / double depression (85%) dysthymic disorder 56% OCD (26%) PTSD (59%).

Bobes et al compared the quality of life in Spanish population with depressed outpatients, patients on haemodialysis, and kidney transplant recipients – OCD patients reported the same quality of life as schizophrenics in the areas of mental health, but better in the areas of physical health compared with heroin dependents and depressed patients, their quality of life was worse.

In a study by Nideauer, and others on the quality of life in individuals with OCD, the social and familial relationships and the occupational performance (capacity to work and study) were the areas most severely affected by the disorder, and although there was an improvement with the treatment, these areas remain at a poor level of performance.

Stengler Wenzke (2006) and others compared the subjective quality of life (QOL) in patients with OCD and general population and to patients with schizophrenia and concluded that OCD has a substantial adverse effect on patients subjective QOL which may be even greater than the adverse effects of schizophrenia.

Stengler – Wenzke (2007) and others found compulsions reduced patient QOL where as obsessions did not have any impact on QOL

ratings. Depressive symptoms were strong predictors of QOL in OCD patients.

Fineberg NA, Fouril H, Gale TM, Sivakumaran T (2005) UK, compared OCD patients with comorbid depression to a group patients with major depression (MDD) and found that the OCD groups was significantly more symptomatic and items 3 (inner tension) and 9 (pessimistic thoughts) and less symptomatic on items 4 (sleep) and 5 (appetite).

Calvocoressi (1988) compared in patient group of OCD with. Schizophernia and depressive disorder group. He concluded that these groups had worse employment histories, lost more time from work, and poorly performed activities of daily living.

Social adjustment and social functioning was found to be moderately impaired in out patient OCD population, mild to moderate problems in outpatient samples in the areas of family functioning was reported.

Sexual dissatisfaction upto 70% of outpatient sample (Steketee 1977) staebler and other (1993) compared sexual dissatisfaction in outpatient group with panic disorder and depression, reported upto 60% had dissatisfaction, but qualitatively not different from other groups.

In a study conducted by Moritz (2008) and colleagues found 2-4 standard deviations lower than those of a healthy subsample on the role physical, general health, vitality, social functioning, role emotional.

Gururaj GP, Badamath. S., and others (2008) from OCD clinic, Dept. from Psychiatry, NIMHANS, Bangalore, India, compared OCD and schizophrenic patients and concluded that severe OCD is associated with significant disability, poor quality of life, often comparable to schizophrenia.

Vikas A, Avasthi and others from Chandigarch, India (2009) compared the QOL with depressive disorder patients and found that patients with OCD had a better quality of life (QOL) and were less disabled compared with depressed patients.

AIMS AND OBJECTIVES

- To describe the clinical features of obsessive compulsive disorder.

- To assess the quality of life among obsessive compulsive disorder.

MATERIALS AND METHODS

SETTING OF STUDY

The study was carried out at the psychiatry OPD at Government Stanley Medical College and Hospital, Chennai.

STUDY PERIOD

The study was carried out over a six month period from January 2009 to June 2009.

STUDY SAMPLE

30 consecutive patients who satisfied the criteria for obsessive compulsive disorder and 30 patients who satisfied the criteria for depression according to ICD 10 diagnostic criteria were recruited for the study.

DESIGN OF STUDY

Case Control Study.

SELECTION OF SAMPLE

30 consecutive patients fulfilling the inclusion criteria were taken as the study sample.

30 consecutive patients fulfilling the inclusion criteria were taken as the control population.

INCLUSION CRITERIA

1. Diagnosed as obsessive compulsive disorder according to ICD 10 criteria.
2. Duration of illness greater than six months.
3. No evidence of organic disease.
4. Willing to provide informed consent for the interview.

EXCLUSION CRITERIA

1. Uncooperative patients
2. Refusal to participate in the study.
3. Duration of illness less than six months.
4. Patients with evidence of organic disease.
5. OCD with psychotic features.

CONTROLS

30 consecutive patients who satisfied the criteria for depression according to ICD 10 diagnostic criteria attending the OPD, Stanley Medical College Hospital, Chennai.

INCLUSION CRITERIA

1. Diagnosed as Depression according to ICD 10 criteria.
2. Willing to provide informed consent for the interview.
3. No evidence of organic disease.

EXCLUSION CRITERIA

1. Uncooperative patients
2. Refusal to participate in study.
3. Patients with evidence of organic disease.
4. Depression with psychotic features.

TOOLS

1. Semi structured proforma for socio demographic Data,

    * Age
    * Sex

* Educational Status
* Marital Status
* Employment Status
* Socio economic status
* Family history

2. Self checklist for Obsessive – Compulsive disorders (OCD)

3. Yale Brown obsessive compulsive scale (Y Bocs)

4. Hamilton Depression rating scale (Ham-D).

5. World Health Organization Quality of life (WHO QOL) BREF.

YALE-BROWN OBSESSIVE COMPULSIVE SCALE-YBOCS.

The Y-BOCS developed by W.Goodman et al., is used to measure the severity of symptoms in obsessive compulsive disorder. It has questions which are divided in to two domains-have five questions each. One is for obsessions and another is for compulsions. The response to each question is rated on likert type of scoring from 0-4, where ‘o’ denotes no active symptoms and ‘4’ indicates severe symptoms. The total score for each item is added together to get the totaldomain score for obsession and compulsion. These two scores put together will give the

total score on both obsession and compulsions. The total score out of 40 is then grouped in to subclinical to extreme score.

QUESTIONS

1. Time spent
2. Interference
3. Distress
4. Resistance
5. Control over symptom

RANGE OF SEVERITY

0-7	subclinical
8-15	mild
16-23	moderate
24-31	severe
32-40	extreme

HAMILTON DEPRESSION RATING SCALE, (HDRS)

The HDRS (also known as HAM-D) is the most widely used clinician administered depression assessment scale. The original version contain 17 items (HDRS17) pertaining to symptoms of depression experienced over the past 2 week.

SCORING

Method for scoring varies by version for the HDRS 17 a score of 0-7 is generally accepted to be within the normal range (or in clinical remission) while a score of 20 or higher indicating atleast moderate severity is usually required for entry in to a clinical trial Numerous versions with varying lengths include the HDRS 17. HDRS 21, HDRS 29, HDRS 8, HDRS 6, HDRS 24, HDRS 7, in this study HDRS17 is used.

PROCEDURE

The thesis and its methodology were discussed and approved by the Ethics committee of the research panel of Stanley medical college, Chennai Subjects in this study consisted of thirty patients of obsessive compulsive disorder and thirty patients of depression from the out patient department of Stanley medical college hospital Chennai. All the patients were diagnosed using the ICD -10 diagnostic criteria.

Informed consent was obtained from each patient.

The scales were applied at the time of the study measuring the current status.

The data thus collected was tabulated and discussed with reference to the aims and objectives the study

ANALYSIS

The cases and controls were analysed for the study findings. Frequency distribution was done using EPI 6 Info (WHO). For comparison, we used chi square tests for testing the association and the difference in means was calculated using student ‘t’ test. These tests were performed using SPSS version 16. In addition, we generated some charts using the Microsoft word. Important findings of relevance, both positive and negative are presented and discussed.

RESULTS AND DISCUSSION

As this is a case control study, I compared the cases and controls for various characteristics.

SOCIO DEMOGRAPHIC INFORMATION

The cases and controls were compared for the following: age, gender, marital status, living status, religion, educational level and employment status.

TABLE - 1

COMPARISON OF AGE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Mean	Std. Deviation	df	't' value	'p' value
Cases (OCD)	30	29.3333	7.64890	58	-2.448	.017*
Controls (Depression)	30	36.3000	13.58028			

Compared with depressives, OCD patients are younger and this difference is statistically significant (p = 0.017).

TABLE - 2

COMPARISON OF GENDER BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	**N**	**Males**	**females**	**df**	**'chi' value**	**'p' value**
Cases (OCD)	30	19	11	1	5.406	0.019*
Controls (Depression)	30	10	20			

Compared with depressives, there are more male OCD patients this difference is statistically significant (p = 0.019).

TABLE – 3

COMPARISON OF MARITAL STATUS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	**N**	**Married**	**Unmarried**	**df**	**'chi' value**	**'p' value**
Cases (OCD)	30	16	14	1	3.59	0.058
Controls (Depression)	30	23	7			

There is no statistical difference for marital status between the cases and controls.

TABLE – 4

COMPARISON OF LIVING STATUS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	With parents	With Spouse	df	'chi' value	'p' value
Cases (OCD)	30	15	15	1	7.5	0.006*
Controls (Depression)	30	5	25			

There is statistically significant difference for living status between the cases and controls; more people with OCD are living with parents compared with depressive patients.

TABLE – 5

COMPARISON OF LIVING ARRANGEMENT (ACCOMMODATION) BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Own	Rental & Others	df	'chi' value	'p' value
Cases (OCD)	30	14	16	1	3.59	0.058
Controls (Depression)	30	7	23			

There is no statistically significant difference for living arrangement between the cases and controls.

TABLE – 6

COMPARISON OF RELIGION BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	**N**	**Hindus**	**Others**	**df**	**'chi' value**	**'p' value**
Cases (OCD)	30	24	6	1	0.48	0.488
Controls (Depression)	30	26	4			

There is no statistically significant difference for religion between the cases and controls.

TABLE – 7

COMPARISON OF EDUCATIONAL LEVEL BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Illiterate and Primary	Secondary and above	df	'chi' value	'p' value
Cases (OCD)	30	5	25	1	8.86	0.003**
Controls (Depression)	30	16	14			

There is statistically significant difference for educational level between the cases and controls; more OCD patients have secondary and high levels of education compared with depressive patients.

TABLE - 8

COMPARISON OF EMPLOYMENT STATUS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Unemployed	Employed	Others (Student/ housewife)	df	'chi' value	'p' value
Cases (OCD)	30	7	16	7	2	3.275	0.77
Controls (Depression)	30	5	15	10			

TABLE - 9

COMPARISON OF RURAL/URBAN STATUS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Urban	Semi Urban	Rural	df	'chi' value	'p' value
Cases (OCD)	30	19	4	7	2	0.32	0.852
Controls (Depression)	30	21	3	6			

There is no statistically significant difference for urban/rural status between the cases and controls.

In summary, the OCD patients are younger, predominantly males, more educated and living with parents compared with depressives. On the other hand, these two groups are comparable for their socio economic background and employment status.

FAMILY HISTORY

TABLE – 10

COMPARISON OF FAMILY HISTORY OF PSYCHIATRIC ILLNESS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Family History of Psy Disoder +	No Family History of Psy Disoder	df	'chi' value	'p' value
Cases (OCD)	30	11	19	1	2.052	0.126
Controls (Depression)	30	6	24			

It is important to observe that 36.7 % of OCD patients have a family history of psychiatric disorder compared with 20 % of depressive patients but this difference was not statistically significant.

TABLE - 11

COMPARISON OF FAMILY HISTORY OF SUBSTANCE USE, INCLUDING ALCOHOL BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Alcohol or substance use in family member	No Alcohol or substance use in family member	df	'chi' value	'p' value
Cases (OCD)	30	6	24	1	0.48	0.365
Controls (Depression)	30	4	26			

It is observed that no statistically significant difference exist between the two groups for family history of substance use.

TABLE - 12
COMPARISON OF FAMILY HISTORY OF SUICIDE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Suicide/attempted suicide in family member	No Suicide/attempted suicide in family member	df	'chi' value	'p' value
Cases (OCD)	30	6	24	1	0.373	0.381
Controls (Depression)	30	8	22			

It is observed that no statistically significant difference exist between the two groups for family history of suicide / attempted suicide.

Overall, there exists no difference between the cases and controls in family history of psychiatric disorder, substance use and suicide/attempted suicide.

SUBSTANCE USE HISTORY

TABLE - 13
COMPARISON OF HISTORY OF TOBACCO USE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	History of tobacco use	No tobacco use	df	'chi' value	'p' value
Cases (OCD)	30	2	28	1	0.218	0.5
Controls (Depression)	30	3	27			

It is observed that no statistically significant difference exist between the two groups for history of tobacco use.

TABLE – 14

COMPARISON OF HISTORY OF ALCOHOL USE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	History of alcohol use	No alcohol use	df	'chi' value	'p' value
Cases (OCD)	30	6	24	1	2.308	0.127
Controls (Depression)	30	2	28			

It is observed that no statistically significant difference exist between the two groups for history of alcohol use.

TABLE – 15

COMPARISON OF HISTORY OF DRUG USE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	History of drug use	No drug use	df	'chi' value	'p' value
Cases (OCD)	30	2	28	1	2.069	0.246
Controls (Depression)	30	0	30			

It is observed that no statistically significant difference exist between the two groups for history of drug use.

MEDICAL HISTORY

TABLE - 16
COMPARISON OF PAST HISTORY OF MEDICAL ILLNESS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Past History of medical illness	No Past History of medical illness	df	'chi' value	'p' value
Cases (OCD)	30	2	27	1	5.189	0.024*
Controls (Depression)	30	9	21			

It is observed that there is a statistically significant difference between the two groups for past history of medical illness. Compared with OCD patients, depressives have more past history of medical illnesses.

PSYCHIATRIC HISTORY

TABLE - 16
COMPARISON OF PAST HISTORY OF MEDICAL ILLNESS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Past History of psychiatric treatment	No Past History of psychiatric treatment	df	'chi' value	'p' value
Cases (OCD)	30	8	22	1	0.373	0.381
Controls (Depression)	30	6	24			

It is observed that there is no statistically significant difference between the two groups for past history of psychiatric treatment.

CLINICAL FEATURES OF OBSESSIVE COMPULSIVE DISORDER

The clinical features of the thirty patients with Obsessive Compulsive Disorder was studied in greater detail. Clinical description of the patients were recorded in detail utilizing the psychiatric interview schedule that is used in our clinic settings. Content analysis of the mental status examination was done and examples of specific obsessions and compulsions noticed in this group is presented.

In our study 30 patients fulfilled the criteria of obsessive compulsive disorder. Out of 30 patients 13 patients had “fear of contamination” and an equal number presented with “washing” compulsion. Most of the studies in India and the world found that the fear of contamination is the commonest obsession and washing is the commonest compulsion amongst OCD patients.

In our study four patients had pathological doubt with checking compulsion. Among the four patients, one patient had mixed obsessive (sexual obsessions) features.

Three patients had obsessive thought of fear of harming others (aggression).

Three patients had obsession for symmetry.

The compulsions seen in the study participants included: cleaning/washing, checking, repeating acts, order and symmetry, mental compulsions and counting. These clinical features are similar to what is being observed in most clinical studies of Obsessive Compulsive Disorder.

The thirty patients with OCD were administered Y-BOCS scale and the results are as follows.

TABLE - 17

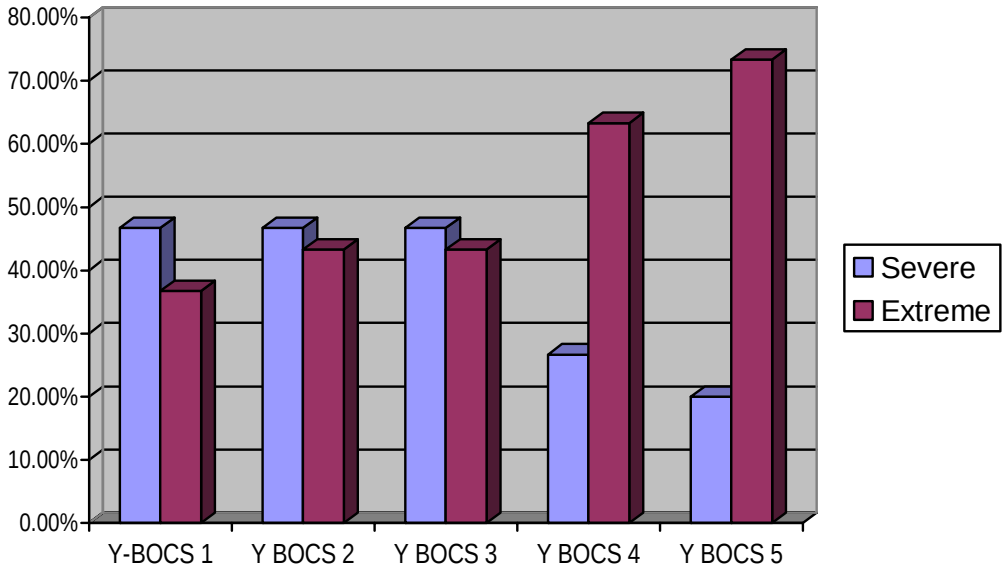
FREQUENCY DISTRIBUTION OF SEVERITY OF OBSESSION AND COMPULSION SYMPTOMS ELICITED BY Y-BOCS IN PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER (N =30)

Symptoms	None	Mild	Moderate	Severe	Extreme
1	0	1 (3.3%)	4 (13.3%)	14 (46.7%)	11 (36.7%)
2	0	0	3 (10%)	14 (46.7%)	13 (43.3%)
3	0	0	3 (10%)	14 (46.7%)	13 (43.3%)
4	0	0	3 (10%)	8 (26.7%)	19 (63.3%)
5	0	0	2 (6.7%)	6 (20%)	22 (73.3%)
6	5 (16.7%)	4 (13.3%)	7 (23.3%)	13 (43.3%)	1 (3.3%)
7	5 (16.7%)	3 (10%)	4 (13.3%)	13 (43.3%)	5 (16.7%)
8	6 (20%)	2 (6.7%)	4 (13.3%)	14 (46.7%)	4 (13.3%)
9	5 (16.7%)	1 (3.3%)	4 (13.3%)	10 (33.3%)	10 (33.3%)
10	5 (16.7%)	1 (3.3%)	4 (13.3%)	4 (13.3%)	16 (53.3%)

OBSESSIONS

FIGURE – 1

SEVERITY OF OBSESSION SYMPTOMS

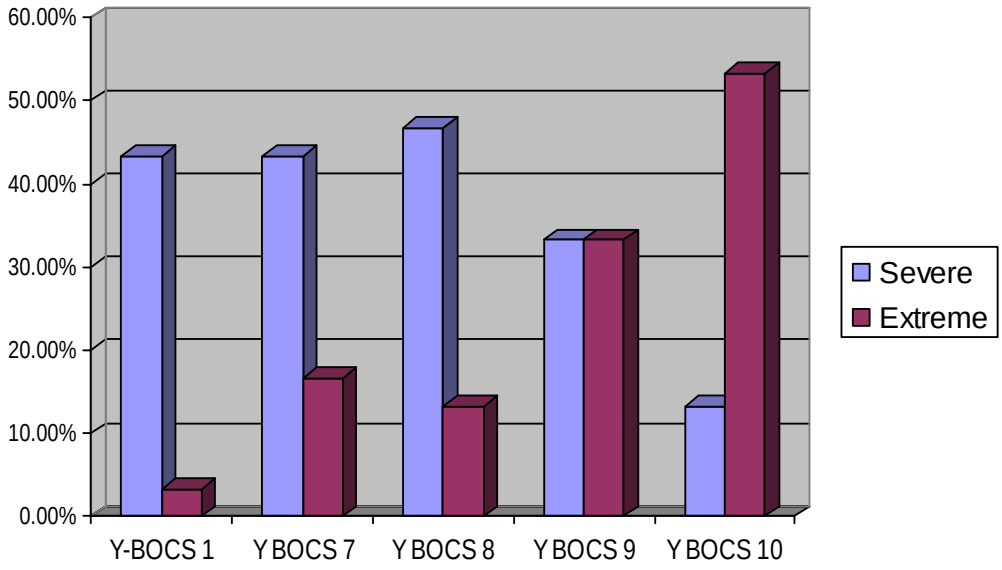


About a half of the patients (46.7%) spent more than three hours but less than 8 hours every day on obsessions; more than a third of them (36.7%) spent more than 8 hours every day on their obsessions. About a half of OCD patients (46.7%) had impaired levels of functioning due to their obsessions and 43.3% of the patients had incapacitating levels of interference due to their obsessions. Distress due to obsessions was severe in 46.7% of cases and near constant and disabling among 43.3% of OCD patients. About three fourths (73.3%) of the OCD patients had no control over their obsessions. About two thirds of OCD patients (63.3%) completely yielded to their obsessions.

COMPULSIONS

FIGURE – 2

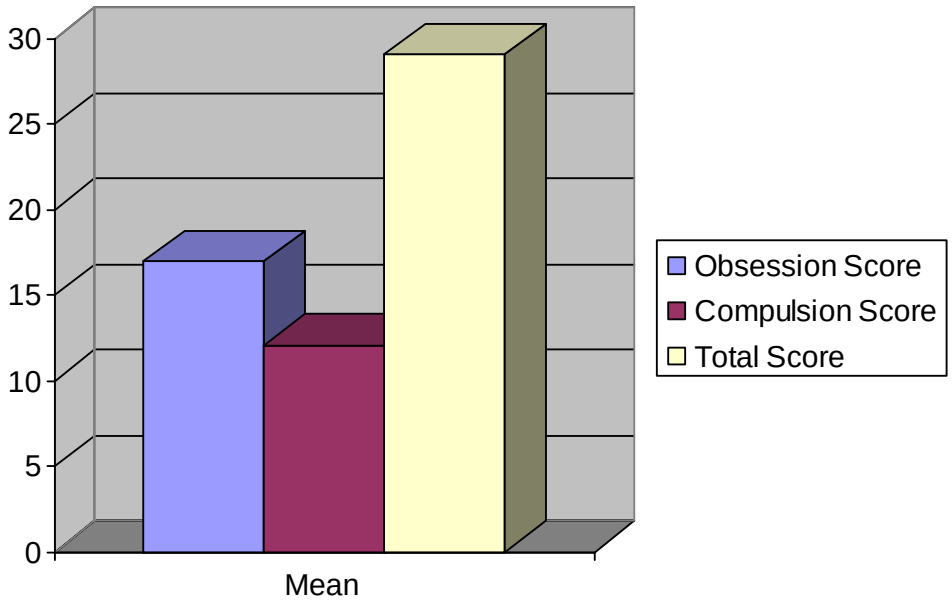
SEVERITY OF COMPULSION SYMPTOMS



Of the 30 OCD patients, 43.3% of them spent between 3-8 hours on their compulsions every day. Same proportion of patients (43.3%) experienced inpaired levels of functioning due to their compulsions. About a half (46.7%) of the OCD patients had severe degree of distress as an adverse consequence to their compulsions. Two- thirds (66.6%) of each of OCD clients studied often yielded or completely yielded to their compulsions. More than a half (53.3%) of the OCD patients had no control over their compulsions.

FIGURE 3

MEAN SCORES FROM Y-BOCS FOR TOTAL, OBSESSION AND COMPULSION



Overall, it is apparent that majority of the patients have obsessions and compulsions that afflict them significantly and cause marked distress and dysfunction.

DEPRESSIVE SYMPTOMS AMONG OBSESSIVE COMPULSIVE DISORDER PATIENTS

The cases and controls were compared for depressive score obtained through Hamilton Depression Rating scale (HAM D)

TABLE – 1

COMPARISON OF HAM D TOTAL SCORE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Mean	Std. Deviation	df	't' value	'p' value
Cases (OCD)	30	16.6	8.5646	57		.*
Controls (Depression)	29	26.3	4.936			

Compared with OCD patients, depressives have a higher mean score in HAM D. Yet it important to note that the mean score of HAM D among OCD patients is 17 (16.6) and the cut-off score in HAM D for significant depression is

PROPORTION OF OCD PATIENTS WITH NO DEPRESSIVE SYMPTOMS

HAM D Symptom	% of absent or no symptom
1. Depressed Mood	2 (6.6%)
2. Feelings of guilt	5 (16.7%)
3. Suicide	14 (46.7%)
4. Insomnia Early night	11 (36.7%)
5. Insomnia Middle night	15 (50%)
6. Insomnia Early morning	16 (53.3%)
7. Work and activity	6 (20%)
8. Retardation	22 (73.3%)
9. Agitation	4 (13.3%)
10. Anxiety Psychic	4 (13.3%)
11. Anxiety Somatic	1 (3.3%)
12. Somatic gastrointestinal	25 (83.3%)
13. General somatic	12 (40%)
14. Genital symptoms	22 (73.3%)
15. Hypochondriasis	18 (60%)
16. Loss of weight	25 (83.3%)
17. Insight	30 (100%)

QUALITY OF LIFE – RATING

TABLE – 18

COMPARISON OF QUALITY OF LIFE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Very poor	Poor	Neutral	Good	df	'chi' value	'p' value
Cases (OCD)	30	9	7	11	2	3	9.399	0.024*
Controls (Depression)	30	16	11	2	1			

The quality of life is very poor among the depressives compared with obsessive compulsive disorder and this difference was statistically significant.

TABLE - 19

COMPARISON OF QUALITY OF LIFE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	9	11	7	3	3	3.475	0.324
Controls (Depression)	30	8	13	9	0			

The quality of life rating for satisfaction is similar among the depressives and obsessive compulsive disorder patients with no statistically significant difference.

EXPERIENCE, LAST FOUR WEEKS

TABLE – 20

COMPARISON OF PHYSICAL PAIN BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	Very much	Extreme	df	'chi' value	'p' value
Cases (OCD)	30	2	2	7	10	9	4	24.111	0.000
Controls (Depression)	30	0	1	2	0	27			

Compared with OCD patients, depressives experience more physical pain and the difference is statistically significant.

TABLE - 21

COMPARISON OF NEED FOR MEDICAL TREATMENT BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Extreme	Very much	df	'chi' value	'p' value
Cases (OCD)	30	9	21	1	0.341	0.386
Controls (Depression)	30	7	23			

There is no difference in need for medical treatment between the OCD patients and depressives.

TABLE - 22

COMPARISON OF ENJOYING LIFE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	Extreme	df	'chi' value	'p' value
Cases (OCD)	30	6	19	5	0	3	5.622	0.132
Controls (Depression)	30	13	14	2	1			

Comparison between the two groups reveal no statistically significant difference between the item 'enjoying the life'.

TABLE – 23

COMPARISON OF MEANINGFULNESS OF LIFE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	Very much	df	'chi' value	'p' value
Cases (OCD)	30	3	18	7	2	3	7.358	0.061
Controls (Depression)	30	12	13	4	1			

More depressive patients than OCD patients state that life is not meaningful at all and this difference is statistically significant.

TABLE - 24

COMPARISON OF CONCENTRATION BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	df	'chi' value	'p' value
Cases (OCD)	30	8	19	3	2	0.912	0.634
Controls (Depression)	30	5	22	3			

There is no difference in concentration between the OCD patients and depressives.

TABLE - 25

COMPARISON OF FEELING OF SAFETY BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	Very much	df	'chi' value	'p' value
Cases (OCD)	30	4	11	14	1	3	1.813	0.612
Controls (Depression)	30	5	15	9	1			

No statistically significant difference was observed for feeling of safety between the two groups.

TABLE - 26

COMPARISON OF PHYSICAL ENVIRONMENT BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	Very much	df	'chi' value	'p' value
Cases (OCD)	30	2	0	7	21	3	9.621	0.022*
Controls (Depression)	30	0	1	17	12			

More OCD patients experience more healthy physical environment compard with depressives and this difference is statistically significant.

EXPERIENCE OR ABLE TO DO CERTAIN THINGS, LAST FOUR WEEKS

TABLE – 27

COMPARISON OF ENERGY BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Not at all	Little	Moderate	Mostly	df	'chi' value	'p' value
Cases (OCD)	30	2	13	14	1	3	8.388	0.039*
Controls (Depression)	30	6	19	5	0			

More OCD patients have moderate levels of energy compared with depressives and this difference is statistically significant.

TABLE - 28

COMPARISON OF BODY APPEARANCE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Not at all	Little	Moderate	Mostly	Completely	df	'chi' value	'p' value
Cases (OCD)	30	2	4	4	18	2	4	7.429	0.115
Controls (Depression)	30	0	1	11	17	1			

There was no statistically significant difference between the two groups for body appearance.

TABLE - 29

COMPARISON OF MONEY TO MEET NEEDS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Not at all	Little	Moderate	Mostly	df	'chi' value	'p' value
Cases (OCD)	30	1	6	18	5	3	11.045	0.011*
Controls (Depression)	30	0	16	14	0			

More OCD patients have money to meet needs compared with depressives and this difference is statistically significant.

TABLE - 29

COMPARISON OF INFORMATION BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Moderate	Mostly	Completely	df	'chi' value	'p' value
Cases (OCD)	30	2	25	3	2	5.861	0.053
Controls (Depression)	30	7	23	0			

No statistically significant difference was observed between the two groups for information.

TABLE - 30

COMPARISON OF LEISURE ACTIVITY BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Little	Moderate	Mostly	df	'chi' value	'p' value
Cases (OCD)	30	1	24	5	2	0.112	0.945
Controls (Depression)	30	1	23	6			

Leisure activity was similar in the two groups.

TABLE – 31

COMPARISON OF ABILITY TO GET AROUND BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Very poor	Poor	Neutral	Good	Very good	df	'chi' value	'p' value
Cases (OCD)	30	0	2	0	13	15	4	21.069	0.000 ***
Controls (Depression)	30	1	5	6	17	1			

More OCD patients have ability to get around compared with depressives and this difference is statistically significant.

TABLE - 32

COMPARISON OF SLEEP BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	5	10	8	7	3	14.73	0.002 **
Controls (Depression)	30	10	18	0	2			

More OCD patients have better sleep compared with depressives and this difference is statistically significant.

TABLE - 33

COMPARISON OF DAILY PERFORMANCE ABILITY BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	6	13	3	8	3	1.426	0.7
Controls (Depression)	30	6	17	2	5			

The daily performance ability was similar between the two groups and there was no statistically significant difference.

TABLE - 34

COMPARISON OF CAPACITY FOR WORK BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	4	13	7	6	3	3.501	0.321
Controls (Depression)	30	6	14	2	8			

There was no statistically significant difference between the two groups for capacity for work.

TABLE - 35

COMPARISON OF SATISFACTION WITH WORK BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	7	17	3	3	3	1.25	0.741
Controls (Depression)	30	9	17	3	1			

The satisfaction with work was similar between the two groups and there was no statistically significant difference.

TABLE - 36

COMPARISON OF PERSONAL RELATIONSHIP BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases /Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	1	4	10	13	2	4	9.214	0.056
Controls (Depression)	30	6	9	7	8	0			

There was no statistically significant difference between the two groups for personal relationship

TABLE - 37

COMPARISON OF SUPPORT FROM FRIENDS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	2	18	9	1	3	1.837	0.607
Controls (Depression)	30	4	16	10	0			

No statistically significant difference was observed for support from friends between the two groups

TABLE – 38

COMPARISON OF LIVING PLACE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/ Controls	N	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	1	2	4	22	1	4	7.294	0.121
Controls (Depression)	30	0	1	0	29	0			

There was no statistically significant difference between the two groups for living place.

TABLE – 39

COMPARISON OF ACCESS TO HEALTH SERVICE BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Dissatisfied	Neutral	Satisfied	Very Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	1	1	26	2	3	4.286	0.232
Controls (Depression)	30	0	0	30	0			

No statistically significant difference was observed for health service between the two groups.

TABLE - 40

COMPARISON OF TRANSPORTATION ACCESS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Dissatisfied	Neutral	Very Satisfied	df	'chi' value	'p' value
Cases (OCD)	30	1	27	2	2	3.158	0.206
Controls (Depression)	30	0	30	0			

The transportation was similar between the two groups and there was no statistically significant difference.

EXPERIENCE, FELT, LAST FOUR WEEKS

TABLE - 41

COMPARISON OF NEGATIVE FEELINGS BETWEEN OBSESSIVE COMPULSIVE DISORDER (CASES) AND DEPRESSION (CONTROLS)

Cases/Controls	N	Always	Very often	Quite often	Seldom	df	'chi' value	'p' value
Cases (OCD)	30	5	13	11	1	3	6.66	0.084
Controls (Depression)	30	11	15	4	0			

Though more depressives seem to feel negative emotions this is not statistically significant.

We found a predominance of younger persons in our sample compared with Depressives. Findings suggest that younger adults and older adolescents may be particularly prone to develop OCD, while older individuals may display OCD less frequently (Fontenelle & Hasler, 2008). We also found the OCD patients to be more educated compared with depressives. Some clinical studies have suggested that higher IQs (Lewis, 1986) and educational achievements characterized individuals with OCD ((Fontenelle et al., 2004). Family history of psychiatric disorder was high among the OCD patients. it is already suggested that there might be an

"OCD spectrum" of disorders that share some of the same vulnerability genes, such as Tourette syndrome, body dysmorphic disorder, grooming behaviors and obsessive–compulsive personality disorder (Fontenelle & Hasler, 2008). We have not assessed the nature of psychiatric disorder among the family members of OCD patients. It is desirable that in future we identify the nature of illness in the psychiatric disorders among family members.

Distress due to obsessions was severe in about half of our cases and near constant and disabling among 43% of OCD patients. About three fourths of the OCD patients had no control over their obsessions and about two thirds of OCD patients completely yielded to their obsessions. Many studies have observed that the symptoms are quite distressing causing significant handicap to the person. WHO has included OCD among the leading ten handicapping illnesses. The common symptoms presented in our sample are cleaning/washing, checking, repeating acts, order and symmetry, mental compulsions and counting. A study by Foa et al, found similar set of compulsive acts in their study (Foa et al, 1995).

Depression is an important co-morbidity among our sample. The mean score of HAM-D in our OCD patients was 16.6. Those OCD patients with co-morbid depression report greater decrements in their subjective feelings, social relations, and in overall well being (Cassin et al, 2009).

In our study we found that the quality of life was impaired in OCD patients. Sixteen patients (53.3%) have poor-very poor quality of life as assessed by WHO-BREF. Previous research has demonstrated that core aspects of quality of life are significantly affected in OCD. The impairment is greater in the presence of depressive co-morbidity.

We found differences in QoL between OCD and Depressive patients in that those with OCD had a better QoL compared with major depression. In a study by Rapaport et al (2005), the authors noted that 26% of OCD patients had clinically severe impairment compared with 63% of patients with depressive disorders. Vikas et al, 2009 conducted a similar study like ours and compared 32 OCD patients and 30 patients of depression in Chandigarh, India. Similar to our findings, they found OCD patients have a better QoL compared with depressed subjects. We found in our study that OCD patients had better energy levels and better sleep.

In addition, they were able to get around better and had more money to meet their needs. Though QoL is better in OCD patients compared with depressives, still they have distressing symptoms and significant impairment to QoL. Hence it is important to identify them early and intervene effectively. Given the presence of co-morbid depressive symptoms, it is desirable to target these symptoms also through pharmacological and cognitive behavioural techniques (Cassin et al, 2009).

LIMITATIONS

The study was conducted in tertiary care context, a medical college hospital psychiatric department. It is likely that all forms of Obsessive Compulsive Disorder is not well represented in this study. Hence the study findings cannot be generalized. Further, only a total of thirty patients could be included in this study. A larger sample involving cases recruited from the community would have been ideal but the limitation of time and resources did not permit such a design.

SUMMARY AND CONCLUSION

A comparative study was conducted at the Psychiatric Outpatient department of the Stanley Medical College Hospital, Chennai. The objectives of the study were to assess the quality of life and the clinical features of obsessive compulsive disorder. Persons satisfying the ICD-10 criteria for obsessive compulsive disorder (OCD) were recruited as subjects (N =30) and matched controls with a clinical diagnosis of major depression were selected (N = 30) from the outpatient department of the same hospital. The cases and controls were interviewed with a structured clinical interview schedule and were assessed for quality of life using WHO QOL-BREF. The cases were administered the Yale brown obsessive compulsive symptom check list. In addition the cases and controls were assessed in detail using Hamilton depression rating scale.

Compared with patients with major depression, OCD patients are young (p=0.017), predominantly males (p=0.019), more educated (p=0.003) and have less past history of medical illnesses (p=0.024). About 36.7% of OCD patients have a family history of psychiatric disorder compared with 20% of depressive patients. No statistically significant difference exists between the two groups for family history of

substance use and suicide/attempted suicide. The mean score on Hamilton Rating Scale for Depression was 16.6 for OCD patients. Almost a half (46.7%) of OCD patients had expressed suicidal ideas. Compared with major depression, OCD patients had better quality of life (QoL). Whereas 16 of the patients with major depression rated their QoL as very poor, nine OCD patients rated their QoL as very poor and this difference was statistically significant (p=0.024). The quality of life rating for satisfaction is similar among the depressives and OCD patients. More OCD patients have better levels of energy compared with depressive patients and this difference is statistically significant (p=0.039). More OCD patients have ability to get around compared with depressives and this difference is statistically significant. Compared with depressive patients, OCD patients have less sleep problem (p=0.002) and have more money to meet their needs (p=0.011).

Though the OCD patients have better quality of life compared with major depressives, yet, 16 patients (53.3%) have poor-very poor quality of life. Hence it is important to recognize these disabling disorders early and intervene effectively with evidence based interventions in order to reduce the burden of disease. Often as these patients present additionally with depressive symptoms, psychiatrists should be trained to identify and

treat depression among OCD patients. It is recommended that in addition to treating the disabling obsessive symptoms, managing the depressive symptoms will help to reduce disease burden and improve quality of life in these individuals. The above findings are consistent with the studies by Rapaport et al, 2005; Vikas et al, (2009) from Chandigarh, India; and, Cassin et al, 2009.

Date : _____ Code #

Self checklist for Obsessive – Compulsive Disorder (OCD)

Please circle the appropriate number for each question.

		Does not get in the way of life		**Gets in the way some time**		**Gets in the way much of the time**		**Gets in the way a lot of the time**
1.	Doing certain things even though I don't have to	1	2	3	4	5	6	7
2.	Getting "stuck" on certain words or thoughts	1	2	3	4	5	6	7
3.	Checking things over and over	1	2	3	4	5	6	7
4.	Hating dirt and dirty things	1	2	3	4	5	6	7
5.	Not touching something that someone else has used	1	2	3	4	5	6	7
6.	Needing to have things clean and neat	1	2	3	4	5	6	7
7.	Washing my hands a lot	1	2	3	4	5	6	7
8.	Putting books or things away in a certain order or until they are "just right"	1	2	3	4	5	6	7
9.	Checking my homework to make sure it is just right	1	2	3	4	5	6	7
10.	Checking my homework to make sure it is just right	1	2	3	4	5	6	7
11.	Repeating things over and over again	1	2	3	4	5	6	7
12.	Counting things over and over again	1	2	3	4	5	6	7
13.	Having trouble finishing my school work	1	2	3	4	5	6	7
14.	Using a favourite number to do things that number of times	1	2	3	4	5	6	7
15.	Worrying about doing "bad" things	1	2	3	4	5	6	7
16.	Worrying a lot about doing things "just right"	1	2	3	4	5	6	7

		Does not get in the way of life				Gets in the way some time		Gets in the way much of the time		Gets in the way a lot of the time
17.	Having trouble making up my mind	1	2	3	4	5	6	7		
18.	Repeating certain actions Describe _____	1	2	3	4	5	6	7		
19.	Moving or talking in a special way to avoid bad things from happening	1	2	3	4	5	6	7		
20.	Saying special numbers or words over and over	1	2	3	4	5	6	7		
21.	Other _____	1	2	3	4	5	6	7		
22.	Other _____	1	2	3	4	5	6	7		
23.	Other _____	1	2	3	4	5	6	7		
24.	Other _____	1	2	3	4	5	6	7		

- Modified from the Leyton Obsessional Inventory (revised 1/17/01)

UMMHC Ambulatory Psychiatry
361 Plantation St
Worcester, MA 01605
(508) 856-2537

YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)

Patient's name _____ **Date** _____

Item		None	Mild	Moderate	Severe	Extreme
1. Hours/day spent on obsessions		0	0 to 1	>1 to 3	>3 to 8	>8
	Score	0	1	2	3	4
2. Interference from obsessions		None	Mild	Definite but manageable	Impaired	Incapacitating
	Score	0	1	2	3	4
3. Distress from obsessions		None	Mild	Moderate but manageable	Severe	Near constant, disabling
	Score	0	1	2	3	4
4. Resistance to obsessions		Always resists	Much resistance	Some resistance	Often yields	Completely yields
	Score	0	1	2	3	4
5. Control over obsessions		Complete control	Much control	Moderate control	Little control	No control
	Score	0	1	2	3	4
						Obsession Subscale (0–20)
6. Hours/day spent on compulsions		0	0 to 1	>1 to 3	>3 to 8	>8
	Score	0	1	2	3	4
7. Interference from compulsions		None	Mild	Definite but manageable	Impaired	Incapacitating
	Score	0	1	2	3	4
8. Distress from compulsions		None	Mild	Moderate but manageable	Severe	Near constant, disabling
	Score	0	1	2	3	4
9. Resistance to compulsions		Always resists	Much resistance	Some resistance	Often yields	Completely yields
	Score	0	1	2	3	4
10. Control over compulsions		Complete control	Much control	Moderate control	Little control	No control
	Score	0	1	2	3	4
Comments:						Compulsion Subscale (0–20)
						Total Score (0–40)

Date:									
Total previous score:									

Range of severity: 0–7 Subclinical 8–15 Mild 16–23 Moderate 24–31 Severe 32–40 Extreme
Ratings include observations during interviews as well as average occurrence for each item during the last 7 days.

Source. Adapted with permission from Wayne K. Goodman, M.D. Goodman WK, Price LH, Rasmussen SA, et al.: "The Yale-Brown Obsessive Compulsive Scale." Arch Gen Psychiatry 46:1006–1011, 1989.

3 SUICIDE

0 |_| Absent.
1 |_| Feels life is not worth living.
2 |_| Wishes he/she were dead or any thoughts of possible death to self.
3 |_| Ideas or gestures of suicide.
4 |_| Attempts at suicide (any serious attempt rate 4).

4 INSOMNIA: EARLY IN THE NIGHT

0 |_| No difficulty falling asleep.
1 |_| Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
2 |_| Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT

0 |_| No difficulty.
1 |_| Patient complains of being restless and disturbed during the night.
2 |_| Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING

0 |_| No difficulty.
1 |_| Waking in early hours of the morning but goes back to sleep.
2 |_| Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES

0 |_| No difficulty.
1 |_| Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
2 |_| Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
3 |_| Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
4 |_| Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)

0 |_| Normal speech and thought.
1 |_| Slight retardation during the interview.
2 |_| Obvious retardation during the interview.
3 |_| Interview difficult.
4 |_| Complete stupor.

9 AGITATION

0 |_| None.
1 |_| Fidgetiness.
2 |_| Playing with hands, hair, etc.
3 |_| Moving about, can't sit still.
4 |_| Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC

0 |_| No difficulty.
1 |_| Subjective tension and irritability.
2 |_| Worrying about minor matters.
3 |_| Apprehensive attitude apparent in face or speech.
4 |_| Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:

gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
urinary frequency
sweating

0 |_| Absent.
1 |_| Mild.
2 |_| Moderate.
3 |_| Severe.
4 |_| Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL

0 |_| None.
1 |_| Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 |_| Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS

0 |_| None.
1 |_| Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
2 |_| Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)

0 |_| Absent.
1 |_| Mild.
2 |_| Severe.

15 HYPOCHONDRIASIS

0 |_| Not present.
1 |_| Self-absorption (bodily).
2 |_| Preoccupation with health.
3 |_| Frequent complaints, requests for help, etc.
4 |_| Hypochondriacal delusions.

16 LOSS OF WEIGHT *(RATE EITHER a OR b)*

a) According to the patient:	b) According to weekly measurements:
0 |_| No weight loss.	0 |_| Less than 1 lb weight loss in week.
1 |_| Probable weight loss associated with present illness.	1 |_| Greater than 1 lb weight loss in week.
2 |_| Definite (according to patient) weight loss.	2 |_| Greater than 2 lb weight loss in week.
3 |_| Not assessed.	3 |_| Not assessed.

17 INSIGHT

0 |_| Acknowledges being depressed and ill.
1 |_| Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 |_| Denies being ill at all.

Total score: |_|_|

Hamilton Depression Rating Scale (HDRS)

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

---

1 **DEPRESSED MOOD** *(sadness, hopeless, helpless, worthless)*

0 |_| Absent.
1 |_| These feeling states indicated only on questioning.
2 |_| These feeling states spontaneously reported verbally.
3 |_| Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
4 |_| Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 **FEELINGS OF GUILT**

0 |_| Absent.
1 |_| Self reproach, feels he/she has let people down.
2 |_| Ideas of guilt or rumination over past errors or sinful deeds.
3 |_| Present illness is a punishment. Delusions of guilt.
4 |_| Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.